Ralston Family Physicians
601 Ralston Street, Suite 100
Reno, NV 89503
(775)786-1110 / Fax (775)788-8075

RECORDS RELEASE AUTHORITY

I understand that if the person and/or organizations listed below are not the healthcare providers, health plans, or healthcare clearinghouses, whom must follow the federal policy standards, the health information disclosed as a result of these authorizations may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization. _____ **Int.**

Patient Name: ______________________________ **Date of Birth:** ________________

RELEASE RECORDS TO:

Physician / Facility / Self: ____

Address / Phone: ____

OBTAIN RECORDS FROM:

Physician / Facility: ____

Address / Phone: ____

Information to be released (Pease Be Specific)

___ **Last 2 years of all medical records**

___ **Last 5 years of all medical records**

___ **ONLY dates of service from** __________ **to** __________

___ **Last: LABS XRAY OFFICE NOTE**

___ **Other records (specify)** ____

I understand that as part of my records the following information will be released unless declined below: Diagnosis or treatment of HIV or AIDS, other sexually transmitted diseases, drug, and/or alcohol abuse or treatment, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I understand this authorization will expire 90 days from the date signed and I hereby give my consent to Ralston Family Physicians to follow through with this request. I release the person agency disclosing this information from any liability arising from the release of information to the person/agency designated above. ____ **Int.**

___ Decline the release of ____

Signature ______________________________ **Date** ______________________________

Reason for Leaving ____

Print Name ____